SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form	SERFF Tr Num: STLG-127098935	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 49327
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num: AR MSPAPP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Jennifer Marinas, Rich Phillips, Allison Hulbert	Disposition Date: 09/16/2011
	Date Submitted: 07/18/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 09/16/2011
	State Status Changed: 09/16/2011
Deemer Date:	Created By: Whitney Ochs
Submitted By: Allison Hulbert	Corresponding Filing Tracking Number:
Filing Description:	

March 3, 2011

Re: Sterling Life Insurance Company Medicare Select and Standard Medicare Supplement Insurance Filing: FORMS
NAIC # 77399
NAIC Group #361

Application for the following policies:

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Standard Medicare Supplement:

Medicare Supplement Plan A – Form Number: AR STD A (05/10)
Medicare Supplement Plan B – Form Number: AR STD B (05/10)
Medicare Supplement Plan C – Form Number: AR STD C (05/10)
Medicare Supplement Plan F – Form Number: AR STD F (05/10)
Medicare Supplement Plan G – Form Number: AR STD G (05/10)
Medicare Supplement Plan K – Form Number: AR STD K (05/10)
Medicare Supplement Plan N – Form Number: AR STD N

SELECT Medicare Supplement:

Medicare Select Plan A – Form Number: AR SEL A (05/10)
Medicare Select Plan B – Form Number: AR SEL B (05/10)
Medicare Select Plan C – Form Number: AR SEL C (05/10)
Medicare Select Plan F – Form Number: AR SEL F (05/10)
Medicare Select Plan G – Form Number: AR SEL G (05/10)
Medicare Select Plan K – Form Number: AR SEL K (05/10)
Medicare Select Plan N – Form Number: AR SEL N

State Specific Forms Related to the Above Policies
Application – Form Number: AR MSPAPP

If you have any questions, please do not hesitate to contact me at 360-392-9370 or email allison.hulbert@sterlingplans.com.

Sincerely,
Allison Hulbert
Product Implementation Coordinator
Product Development

Company and Contact

Filing Contact Information

Jennifer Marinas, Legal Assistant
2219 Rimland Drive
jennifer.marinas@sterlingplans.com
360-392-9201 [Phone]

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

P.O. Box 5348
Bellingham, WA 98227

360-647-8632 [FAX]

Filing Company Information

Sterling Life Insurance Company	CoCode: 77399	State of Domicile: Illinois
P.O. Box 5348	Group Code: 361	Company Type: Insurance Company - Life, Accident & Health
Bellingham, WA 98227	Group Name:	State ID Number:
(360) 647-9080 ext. [Phone]	FEIN Number: 13-1867829	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	IL is domicilie state for Sterling LIfe Insurance Company. $50.00 fee required per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	$50.00	07/18/2011	49865074

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
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Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/16/2011	09/16/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	08/17/2011	08/17/2011	Allison Hulbert	09/08/2011	09/15/2011

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
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Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/16/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
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Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form *(revised)*	AR MSPAPP Med Supp Application	Approved-Closed	Yes
Form	AR MSPAPP Med Supp Application	Disapproved	No

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/17/2011
Submitted Date	08/17/2011
Respond By Date	09/19/2011

Dear Jennifer Marinas,

This will acknowledge receipt of the captioned filing.

Objection 1

- AR MSPAPP Med Supp Application, AR MSPAPP (Form)

Comment: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Objection 2

- AR MSPAPP Med Supp Application, AR MSPAPP (Form)

Comment: R & R 27, Sec. 18 B requires the Agent to list any other health insurance policies they have sold to the applicant; both in force policies and policies sold within the past five years that are no longer in force.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/08/2011
Submitted Date	09/15/2011

Dear Stephanie Fowler,

Comments:

Response 1

Comments: Per your objection, we have revised AR MSPAPP, Med Supp Application form and have moved the tobacco use question to the Medical Question section.

Related Objection 1

Applies To:

- AR MSPAPP Med Supp Application, AR MSPAPP (Form)

Comment:

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: Per your objection, we have revices AR MSPAPP, Med Supp Application and have added "number 5" in the Authorization and Verification Informaiton section to include a space for the Agent to list any other health insurance policies they have sold to the applicant; both in force policies and policies sold within the past five years that are no longer in force.

Related Objection 1

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Applies To:

- AR MSPAPP Med Supp Application, AR MSPAPP (Form)

Comment:

R & R 27, Sec. 18 B requires the Agent to list any other health insurance policies they have sold to the applicant; both in force policies and policies sold within the past five years that are no longer in force.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
AR MSPAPP Med Supp Application	AR MSPAPP		Application/Enrollment Form	Revised	STLG-126337628		AR MSPAPP Med Supp Application.pdf
Previous Version							
AR MSPAPP Med Supp Application	*AR MSPAPP*		*Application/Enrollment Form*	*Revised*	*STLG-126337628*		AR MSPAPP Med Supp Application.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Allison Hulbert, Jennifer Marinas, Rich Phillips

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: AR MSPAPP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/16/2011	AR MSPAPP	Application/ Enrollment Form	AR MSPAPP Med Supp Application	Revised	Replaced Form #: App 2010 - AR Previous Filing #: STLG-126337628		AR MSPAPP Med Supp Application.pdf

STERLING HEALTH PLANS

Underwritten by Sterling Life Insurance Company®

Application for Medicare Supplement Insurance
Arkansas

Applicant Information *Please include your full name as it appears on your Medicare ID Card*

Last Name | First Name | Middle Initial

Resident Address | City

ST | Zip | County | Primary Phone Number

Billing Address (*If different than above*) | City

ST | Zip | County | Secondary Phone Number

Email Address

Medicare Information *As it appears on your Medicare ID Card*

Medicare ID # | Part B Effective Date M M 0 1 Y Y Y Y

Plan Selection, Effective Date & Premium Criteria

1. **Policy Choice:** *(Select one)* [☐ Standard ☐ SELECT]
2. **Plan Choice:** *(Select one)*

[☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ "Innovative" F ☐ Plan G ☐ Plan K ☐ Plan N]

3. **Requested Future Effective Date - 1st of Month:** M M Y Y Y Y
4. **Age** *(on the Requested Effective Date)* | **Date of Birth** M M D D Y Y Y Y | **Gender** ☐ M ☐ F
5. **Payment Options: [***(Initial premium must be paid by check, money order or bank draft)***]**

Select Payment Type:

Premium Amount

$.

☐ **Coupon** *(Select billing period)*

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

☐ **Monthly Automatic Premium Collection** *(from your bank account).*
Please complete & submit an APC Authorization form.

☐ **Monthly Credit or Debit Card [***(Visa, MasterCard, Discover credit card or debit card with Visa or MasterCard logo)*
Monthly coupon rate applies. [Please contact Customer Service at [1-800-688-0010] or TTY [711].] **]**

Eligibility

1. a) Did you turn age 65 in the last 6 months or will you prior to the plan effective date? ☐ Yes ☐ No

   b) Did you enroll in Medicare Part B in the last 6 months or will you prior to the plan effective date? ☐ Yes ☐ No

2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   If NO, proceed to Past and Current Coverage.

   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. IF YES,

   a) Will Medicaid pay your premium for this Medicare Supplement policy? ☐ Yes ☐ No

   b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

If you lost or are losing other health insurance coverage and received a notice from a prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may have guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice** from your prior insurer with your application.

Past and Current Coverage

1. If you had a Medicare Advantage policy within the past 63 days (For example, Medicare PFFS, HMO or PPO), fill in your start and end dates below. **If NO, proceed to question 2.**

   a) If you are still covered under this plan, leave "END" blank.

   START DATE M M D D Y Y END DATE M M D D Y Y

   b) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   c) Was this your first time in this type of Medicare Advantage plan? ☐ Yes ☐ No

   d) Did you cancel a Medicare Supplement policy prior to enrolling in this Medicare Advantage plan? ☐ Yes ☐ No

2. Do you have another Medicare Supplement policy in force? **If NO, proceed to question 3.** ☐ Yes ☐ No

   a) **IF YES**, with what company,

   ... and what plan do you have?

   b) **IF YES**, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

3. Have you had ANY other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) **If NO, proceed to next section.** ☐ Yes ☐ No

   a) **IF YES**, with what company,

   ... and what plan do you have?

   b) What are your dates of coverage for the policy listed in 3a? If you are still covered under this plan, leave "END" blank.

   START DATE M M D D Y Y END DATE M M D D Y Y

If question 1b or 2b is answered YES, then the Replacement of Coverage form must be signed and submitted with the application.

Health History and Medication Information

*If you answered **YES** to 1a in the **Eligibility** section, or you qualify for another open enrollment or guaranteed issue period, you may proceed directly to Authorization and Verification of Information on the next page.*

1. **Please answer the following health questions:**

a) Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or have you received home health care in the past 90 days; or has such care been medically advised by a licensed medical practitioner? ☐ Yes ☐ No

b) Have you been diagnosed or treated for Chronic Obstructive Lung / Pulmonary Disease or Emphysema? ☐ Yes ☐ No

c) Have you been diagnosed or treated for Alzheimer's Disease, Parkinson's Disease, Lou Gehrig's Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ Yes ☐ No

d) Have you been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV virus? ☐ Yes ☐ No

e) Have you been diagnosed or treated for Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? ☐ Yes ☐ No

f) Have you been admitted to a hospital three or more times in the last two years? ☐ Yes ☐ No

g) Have you had an organ transplant or been advised by a physician to have an organ transplant? ☐ Yes ☐ No

h) Within the past two years, have you been treated for or been advised by a physician to have treatment for Cancer (excluding skin), Leukemia, Hodgkin's' Disease or Melanoma? ☐ Yes ☐ No

i) Within the past two years, have you been treated for or been advised by a physician to have treatment for Stroke, Heart Attack, Coronary Artery Disease including Angina, Arteriosclerosis or Atherosclerosis or Congestive Heart Failure? ☐ Yes ☐ No

j) Within the past two years, have you been treated for or been advised by a physician to have treatment for Alcoholism, Drug Addiction, Cirrhosis of the Liver, or Renal Failure? ☐ Yes ☐ No

k) Within the past two years, have you received or been advised by a physician to have Oxygen Therapy, Kidney Dialysis, a Defibrillator, Bypass Surgery, Angioplasty, Pacemaker or Stent Placement? ☐ Yes ☐ No

*If you answered **YES** to any question above, you are **NOT** eligible for coverage at this time.*

2. Have you used **tobacco** in the last two years? ☐ Yes ☐ No

3. **Please indicate your height and weight:** ☐ FT. ☐☐ IN. / ☐☐☐ LBS.

4. **Have you been hospitalized or admitted to an extended care facility in the last two years?** ☐ Yes ☐ No
IF YES, please explain below:

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed, if any	Name & Address of Physician

5. **Have you taken any prescriptions or over-the-counter medications within the past 12 months?** ☐ Yes ☐ No
IF YES, please explain below:

Medication	Prescribing Physician	Condition Requiring Medication	Still Taking?

Authorization and Verification of Information

1. **Acknowledgments.** To the best of my knowledge and belief, I represent and agree to the following:
   a) I do not need more than one Medicare Supplement Policy. If I purchase this policy, I may want to evaluate my existing health coverage and decide if I need more than one type of coverage in addition to my Medicare benefits.
   b) I may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
   c) If, after purchasing this policy, I become eligible for Medicaid, benefits and premiums under the Medicare Supplement policy will be suspended during entitlement to benefits under Medicaid for 24 months, as long as suspension is requested within 90 days of becoming eligible for Medicaid. When I am no longer entitled to Medicaid, my suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.
   d) If I am eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and I later become covered by an employer or union-based group health plan, the benefits and premiums under my Medicare Supplement policy can be suspended, if requested, while I am covered under the employer or union-based group health plan. If I suspend my Medicare Supplement policy under these circumstances, and later lose my employer or union based group health plan, my suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing my employer or union-based group health plan.
   e) Counseling services may be available in my state to provide advice concerning the purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).
   f) That the statements contained in the application concerning past and present health conditions are complete, true and correct.
   g) No agent or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
   h) Insurance issued as a result of this application will take effect as specified in the Conditional Receipt.
   i) Plan provisions concerning exceptions, exclusions, limitations and renewal have been explained and understood.
   j) I acknowledge receipt of the **Outline of Coverage** and the **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare** informational booklets.

2. **Representation.** The undersigned applicant and agent acknowledge that the applicant has read or has had read to him/her the completed application and that he/she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.
3. **Payment of Premium.** I acknowledge that I have read the Conditional Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.
4. **Release.** I authorize US Department of Health and Human Services (including Centers for Medicare and Medicaid Services and any contractors or agents), any physician, medical professional, hospital, clinic, pharmacy related services organization, health plan, or insurance company to disclose to Sterling or its reinsurers medical records, prescription records, or other such information upon presentation of this authorization or reproduction thereof. I understand the purpose of this disclosure and use of my information is to evaluate my application for insurance, to determine the amount payable for my claims, and for analytic studies. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for the term of the coverage being applied for and so long thereafter as permissible by law and may be revoked by sending written notice to Sterling. This authorization is a condition of your enrollment in our health plan and your eligibility for benefits.
5. **Agent.** List all policies you have sold to the applicant, including those no longer in force, if sold in the last five years (if none, state "none"):

Policies sold which are still in force:

Policies sold in the past 5 years which are no longer in force:

Applicant's Signature *(Required)*

X_____ Today's Date M M D D Y Y

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Agent Certification: I certify that the Applicant has read, or had read to him/her, the complete application and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ **is or is likely**; ☐ **is not or is not likely** to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent

X_____ Agent #

Print Name Today's Date M M D D Y Y

NOTICE. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate State Agency.

If reply envelope is missing, please mail to the address below or fax to [(360) 685-5950].

SERFF Tracking Number:	*STLG-127098935*	*State:*	*Arkansas*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*49327*
Company Tracking Number:	*AR MSPAPP*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*AR - 2011 Ind. STD/SEL (ABCFGKN) - Application Form*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Flesch Certification
Bypass Reason: Flesch Certification N/A - Application form filing.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
AR MSPAPP Med Supp Application.pdf

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: N/A - No change in rates.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: N/A
Comments:

STERLING HEALTH PLANS

Underwritten by Sterling Life Insurance Company®

Application for Medicare Supplement Insurance
Arkansas

Applicant Information *Please include your full name as it appears on your Medicare ID Card*

Last Name | First Name | Middle Initial

Resident Address | City

ST | Zip | County | Primary Phone Number

Billing Address (*If different than above*) | City

ST | Zip | County | Secondary Phone Number

Email Address

Medicare Information *As it appears on your Medicare ID Card*

Medicare ID # | Part B Effective Date M M 0 1 Y Y Y Y

Plan Selection, Effective Date & Premium Criteria

1. **Policy Choice:** *(Select one)* [☐ Standard ☐ SELECT]
2. **Plan Choice:** *(Select one)*

   [☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ "Innovative" F ☐ Plan G ☐ Plan K ☐ Plan N]
3. **Requested Future Effective Date - 1st of Month:** M M Y Y Y Y
4. Have you used **tobacco** in the last two years? ☐ Yes ☐ No
5. **Age** *(on the Requested Effective Date)* | **Date of Birth** M M D D Y Y Y Y | **Gender** ☐ M ☐ F
6. **Payment Options: [***(Initial premium must be paid by check, money order or bank draft)***]**

   Select Payment Type:

   ☐ **Coupon** *(Select billing period)*

   ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

   ☐ **Monthly Automatic Premium Collection** *(from your bank account). Please complete & submit an APC Authorization form.*

   ☐ **Monthly Credit or Debit Card [***(Visa, MasterCard, Discover credit card or debit card with Visa or MasterCard logo) Monthly coupon rate applies. [Please contact Customer Service at [1-800-688-0010] or TTY [711].]* **]**

Premium Amount

$.

Eligibility

1. a) Did you turn age 65 in the last 6 months or will you prior to the plan effective date? ☐ Yes ☐ No

   b) Did you enroll in Medicare Part B in the last 6 months or will you prior to the plan effective date? ☐ Yes ☐ No

2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   If NO, proceed to Past and Current Coverage.

   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. IF YES,

   a) Will Medicaid pay your premium for this Medicare Supplement policy? ☐ Yes ☐ No

   b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

If you lost or are losing other health insurance coverage and received a notice from a prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may have guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice** from your prior insurer with your applciation.

Past and Current Coverage

1. If you had a Medicare Advantage policy within the past 63 days (For example, Medicare PFFS, HMO or PPO), fill in your start and end dates below. **If NO, proceed to question 2.**

   a) If you are still covered under this plan, leave "END" blank.

   START DATE M M D D Y Y END DATE M M D D Y Y

   b) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   c) Was this your first time in this type of Medicare Advantage plan? ☐ Yes ☐ No

   d) Did you cancel a Medicare Supplement policy prior to enrolling in this Medicare Advantage plan? ☐ Yes ☐ No

2. Do you have another Medicare Supplement policy in force? **If NO, proceed to question 3.** ☐ Yes ☐ No

   a) **IF YES**, with what company,

   ... and what plan do you have?

   b) **IF YES**, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

3. Have you had ANY other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) **If NO, proceed to next section.** ☐ Yes ☐ No

   a) **IF YES**, with what company,

   ... and what plan do you have?

   b) What are your dates of coverage for the policy listed in 3a? If you are still covered under this plan, leave "END" blank.

   START DATE M M D D Y Y END DATE M M D D Y Y

If question 1b or 2b is answered YES, then the Replacement of Coverage form must be signed and submitted with the application.

Health History and Medication Information

*If you answered **YES** to 1a in the **Eligibility** section, or you qualify for another open enrollment or guaranteed issue period, you may proceed directly to Authorization and Verification of Information on the next page.*

1. **Please answer the following health questions:**

a) Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or have you received home health care in the past 90 days; or has such care been medically advised by a licensed medical practitioner? ☐ Yes ☐ No

b) Have you been diagnosed or treated for Chronic Obstructive Lung / Pulmonary Disease or Emphysema? ☐ Yes ☐ No

c) Have you been diagnosed or treated for Alzheimer's Disease, Parkinson's Disease, Lou Gehrig's Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ Yes ☐ No

d) Have you been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV virus? ☐ Yes ☐ No

e) Have you been diagnosed or treated for Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? ☐ Yes ☐ No

f) Have you been admitted to a hospital three or more times in the last two years? ☐ Yes ☐ No

g) Have you had an organ transplant or been advised by a physician to have an organ transplant? ☐ Yes ☐ No

h) Within the past two years, have you been treated for or been advised by a physician to have treatment for Cancer (excluding skin), Leukemia, Hodgkin's' Disease or Melanoma? ☐ Yes ☐ No

i) Within the past two years, have you been treated for or been advised by a physician to have treatment for Stroke, Heart Attack, Coronary Artery Disease including Angina, Arteriosclerosis or Atherosclerosis or Congestive Heart Failure? ☐ Yes ☐ No

j) Within the past two years, have you been treated for or been advised by a physician to have treatment for Alcoholism, Drug Addiction, Cirrhosis of the Liver, or Renal Failure? ☐ Yes ☐ No

k) Within the past two years, have you received or been advised by a physician to have Oxygen Therapy, Kidney Dialysis, a Defibrillator, Bypass Surgery, Angioplasty, Pacemaker or Stent Placement? ☐ Yes ☐ No

*If you answered **YES** to any question above, you are **NOT** eligible for coverage at this time.*

2. **Please indicate your height and weight:** ☐ FT. ☐☐ IN. / ☐☐☐ LBS.

3. **Have you been hospitalized or admitted to an extended care facility in the last two years?** ☐ Yes ☐ No
IF YES, please explain below:

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed, if any	Name & Address of Physician

4. **Have you taken any prescriptions or over-the-counter medications within the past 12 months?** ☐ Yes ☐ No
IF YES, please explain below:

Medication	Prescribing Physician	Condition Requiring Medication	Still Taking?

Authorization and Verification of Information

1. **Acknowledgments.** To the best of my knowledge and belief, I represent and agree to the following:
   a) I do not need more than one Medicare Supplement Policy. If I purchase this policy, I may want to evaluate my existing health coverage and decide if I need more than one type of coverage in addition to my Medicare benefits.
   b) I may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
   c) If, after purchasing this policy, I become eligible for Medicaid, benefits and premiums under the Medicare Supplement policy will be suspended during entitlement to benefits under Medicaid for 24 months, as long as suspension is requested within 90 days of becoming eligible for Medicaid. When I am no longer entitled to Medicaid, my suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.
   d) If I am eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and I later become covered by an employer or union-based group health plan, the benefits and premiums under my Medicare Supplement policy can be suspended, if requested, while I am covered under the employer or union-based group health plan. If I suspend my Medicare Supplement policy under these circumstances, and later lose my employer or union based group health plan, my suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing my employer or union-based group health plan.
   e) Counseling services may be available in my state to provide advice concerning the purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).
   f) That the statements contained in the application concerning past and present health conditions are complete, true and correct.
   g) No agent or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
   h) Insurance issued as a result of this application will take effect as specified in the Conditional Receipt.
   i) Plan provisions concerning exceptions, exclusions, limitations and renewal have been explained and understood.
   j) I acknowledge receipt of the **Outline of Coverage** and the **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare** informational booklets.

2. **Representation.** The undersigned applicant and agent acknowledge that the applicant has read or has had read to him/her the completed application and that he/she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.
3. **Payment of Premium.** I acknowledge that I have read the Conditional Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.
4. **Release.** I authorize US Department of Health and Human Services (including Centers for Medicare and Medicaid Services and any contractors or agents), any physician, medical professional, hospital, clinic, pharmacy related services organization, health plan, or insurance company to disclose to Sterling or its reinsurers medical records, prescription records, or other such information upon presentation of this authorization or reproduction thereof. I understand the purpose of this disclosure and use of my information is to evaluate my application for insurance, to determine the amount payable for my claims, and for analytic studies. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for the term of the coverage being applied for and so long thereafter as permissible by law and may be revoked by sending written notice to Sterling. This authorization is a condition of your enrollment in our health plan and your eligibility for benefits.

Applicant's Signature *(Required)*

X_____ Today's Date M M D D Y Y

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Agent Certification: I certify that the Applicant has read, or had read to him/her, the complete application and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ **is or is likely**; ☐ **is not or is not likely** to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent

X_____ Agent # _____

Print Name _____ Today's Date M M D D Y Y

NOTICE. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate State Agency.

If reply envelope is missing, please mail to the address below or fax to [(360) 685-5950].